STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155531	A. BUILDING _____ B. WING _____	C 02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBROOK VILLAGE	850 ASH ST HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint IN00085696 Complaint IN 00085696- Substantiated, no deficiencies related to the allegations are cited. Survey dates: February 7, 8, 9, &10, 2011 Facility number: 000569 Provider number: 155531 AIM number: 100267660 Survey team: Vicki Bickel, RN- TC Julie White, RN Kim Davis, RN Census bed type: SNF/NF: 41 Total: 41 Census payor type: Medicare: 1 Medicaid: 34 Other: 6 Total: 41 Sample: 12 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2 Quality review completed on February 16, 2011, by Bev Faulkner, RN	F 000	Submission of this Plan of Correction does not constitute an admission agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	**F157 Notification of Changes** It is the policy of this facility to notify the primary physician of significant changes in the resident's condition. **Corrective Action for residents affected:** Physician was notified of the weight gain for resident #10. **Other residents having the potential to be affected:** All other residents have the potential to be affected.	

RECEIVED
MAR - 4 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

approved 3/9/11 RF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Mandel | TITLE: HFA | (X6) DATE: 3-3-2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the physician of 1 resident's weight gain as ordered for 1 of 12 residents reviewed for physician notification in a sample of 12. (Resident # 10)	F 157	**Measures to ensure practice does not reoccur:** All licensed nursing staff were reeducated/in serviced on 2/28/11 regarding physician notification of resident changes in condition. See Attachment B. Nurses' notes, medication and treatment records will be reviewed daily Monday through Friday by the DON/designee for timely physician notification. Such auditing will be evidenced by using the attached audit tool. See Attachment C. Any non-compliance will be addressed immediately through correction, re-education and disciplinary action, as warranted. **This Corrective Action will be monitored by:** The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. **Plan of Correction date: 3/12/2011**	

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F 157	Continued From page 2 Findings include: Review of the clinical record of Resident # 10 on 2/7/11 at 11:00 a.m., indicated the following: Resident # 10's diagnoses included, but were not limited to, status post recent liver transplant on 11/29/2010, COPD (chronic obstructive pulmonary disease), steroid induced hyperglycemia and hypothyroidism. A physician's order, dated 1/7/2011, indicated "...weigh daily, inform liver transplant [sic] (physician/clinic) if weight gain of 3-5 pound over a 24 hour period...." Interview with LPN # 2 on 2/7/11 at 4:25 p.m., indicated daily weights should be recorded in the Medication Administration Record (MAR). The January 2011 MAR indicated Resident # 10 weighed 133.4 pounds on 1/23/11 and weighed 138.0 pounds on 1/24/11. No documentation was found in the nurse's notes to indicate the physician was notified of a 3-5 pound weight gain over a 24 hour period. Interview with the RN/Nurse Consultant on 2/10/11 at 8:55 a.m., indicated the facility was unable to find documentation of evidence the physician was notified of Resident # 10's 3-5 pound weight gain.	F 157		
F 250 SS=D	3.1-5(a)(2) 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250	**F250 Social Services** The facility must provide medically – related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	

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F 250	Continued From page 3 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the maladaptive behaviors of 1 of 6 residents reviewed for behaviors in a sample of 12, were successfully addressed to meet the resident's needs (Resident # 29). Findings include: The initial tour was conducted on 2/7/11 between 10:00 a.m. and 10:30 a.m., with LPN # 1. During the tour, Resident # 29 was observed sitting in a high back wheelchair in the entrance hallway by the nurses station. The resident was heard calling out "Ahhhhhhh Ahhhhhhhh... ." Resident # 29 was observed on 2/7/11 in the assisted dining room between 12:00 p.m. and 12:40 p.m. The resident called out "Ahhhhhh Ahhhhhhhhh." At 12:10 p.m., CNA # 5 stood by the resident and asked "(resident's name) what do you need?" The CNA gave the resident a cup of hot chocolate, which calmed her until 12:15 p.m. when she began to call out again. Resident # 29 was observed in bed at 1:45 p.m. The resident was heard calling out "Ahhhhhhhhh Ahhhhhhhhh." There was a television in the resident's room. It was not turned on.	F 250	**Corrective Action for residents affected:** Resident #29's behavior management plan was reviewed 2/24/11 and updated. Resident #29's care plan was updated to reflect appropriate behavior interventions. **Other residents having the potential to be affected:** All residents behavior management plans were reviewed for appropriate behavior interventions and updated as needed. **Measures to ensure practice does not reoccur:** All residents' behavior management plans are reviewed monthly by the Social Services Director, DON, Administrator, Pharmacist, and Mental Health Services. All nursing staff has been re-educated on behavior management program interventions on 2/28/11 per the Social Service Director and the Corporate Nurse Consultant. Behavior interventions will be monitored randomly 3 times weekly for 4 weeks, then weekly for 2 months, then monthly for 2 months, then quarterly by the Administrator or designee to ensure staff utilizes appropriate interventions as per care plan. Please see Behavior Interventions Monitoring Tool, attachment D. Any non-compliance will be addressed immediately through correction, re-education and disciplinary action, as warranted.	

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F 250	Continued From page 4 Resident # 29 was in the room in the bed with the door closed from 1:45 p.m. until supper time at 5:15 p.m. Staff were observed going into the room at 3:30 p.m. and 5:00 p.m. On 2/8/11, Resident # 29 was observed sitting in the wheelchair by the nurse's station in the main hallway between 7:00 a.m. and 7:25 a.m. The resident was heard calling out. Resident # 29 indicated, "Where's my husband ?... They tell me he's dead...." "Ahhhhhhhhhhh Ahhhhhhhhhhhhh." After breakfast, between 8:30 a.m. and 8:50 a.m., Resident # 29 was observed in the hallway outside her room door. The resident called out "Ahhhhhhhhhhh "Ahhhhhhhhhhhh." She was observed pulling herself down the hall way using the hand rail. At 8:55 a.m., CNA # 3 and CNA # 4 were observed assisting Resident # 29 to bed. The resident's eyes were closed and appeared to be sleeping through the transfer. CNA # 4 was interviewed at 9:00 a.m. on 2/8/11. The CNA indicated the resident would sometimes stay in bed until lunch, and sometimes she did not. At 1:15 p.m. on 2/8/11, the resident was observed in bed, yelling out. The television was not turned on. At 1:25 p.m., the resident was observed sitting on the edge of the bed, holding onto the quarter side rail. The resident was wearing only a tee shirt and a brief. The Social Service Director (SSD) was summoned to the room. He assisted the resident back into the bed.	F 250	**This Corrective Action will be monitored by:** The findings of these audits will be reviewed at the facility's quarterly Quality Assurance meeting and the plan of action adjusted accordingly. **Plan of Correction date: 3/12/2011**	

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F 250	Continued From page 5 The resident was heard calling out from 1:15 p.m. until 2:30 p.m., during the afternoon of 2/8/11. The group meeting was held on 2/8/11 at 10:00 a.m. During the meeting, 5 of the 11 residents present indicated they could hear Resident # 29 calling out at night. The clinical record of Resident # 29 was reviewed on 2/8/11 at 8:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, depression, hip repair, arthritis, and heart disease. The Quarterly Minimum Data Set Assessment (MDS), dated 12/27/10, indicated Resident # 29 was dependent on staff for all activities of daily living. The MDS indicated the resident showed little interest, had little energy, and was tired. The MDS indicated the resident did not display behaviors during the seven day assessment period. The care plan, dated 12/30/10, included, delusional thinking, socially inappropriate behaviors of yelling out, depression, and memory loss. The care plan interventions included, one to one staff, diversions, comfort, and reassurance. The activity care plan interventions included the resident liked to be read to, television, and music. There were no nursing notes related to the resident's behaviors on 2/7/11 or 2/8/11. There were no entries on the February 2011 "Mood and Behavior Monthly Flow Record" had documented	F 250		

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F 250	Continued From page 6 behaviors on 2/1/11 only. The SSD was interviewed on 2/9/11 at 2:20 p.m. The SSD indicated when a resident exhibited a behavior, staff completed a "Mood and Behavior Communication Memo". The SSD indicated he then completed the monthly flow record with the information staff provided on the memos. The SSD indicated the facility did have monthly behavior meetings. He indicated Resident # 29 was discussed. The SSD further indicated the facility staff had requested medications for behaviors from the family physician, but he would not give orders. Further information was requested regarding the behavior management for Resident # 29 at the daily exit meeting on 2/9/11 at 4:00 p.m. No further information was provided by the facility related to the behavior management of Resident # 29 as of the exit on 2/10/11 at 3:00 p.m.	F 250		
F 282 SS=D	3.1-34(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to obtain daily weights as ordered for 1 of 12 residents reviewed for following physician orders (Resident # 10).	F 282	**F282 Services by Qualified Persons per Care Plan** It is the policy of this facility to provide services by qualified persons in accordance with each resident's written plan of care. **Corrective Action for residents affected:** Physician was notified of the missing weights, with no new orders obtained. Resident #10 is no longer in the facility.	

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F 282	Continued From page 7 Findings include: 1. Review of the clinical record of Resident # 10 on 2/7/11 at 11:00 a.m., indicated the following: Resident # 10's diagnoses included, but were not limited to, status post recent liver transplant on 11/29/2010, COPD (chronic obstructive pulmonary disease), steroid induced hyperglycemia and hypothyroidism. A physician's order, dated 1/7/11, indicated "...weigh daily, inform liver transplant [sic] (physician/clinic) if weight gain of 3-5 pound over a 24 hour period...." An admission weight of 138.3 pounds on 1/7/11 was found documented for monthly weights in the clinical record. Interview with LPN # 2 on 2/7/11 at 4:25 p.m., indicated daily weights should be recorded in the Medication Administration Record (MAR). Review of Resident # 10's February MAR on 2/7/11 at 4:30 p.m., indicated a weight of 136.0 on 2/3/11 and a weight of 138.0 on 2/7/11. No additional weights were found documented in the MAR for February. Resident # 10's January 2011 MAR, found in a binder, indicated no weight was recorded on 1/22/11 and 1/31/11. During the daily conference on 2/7/11 at 4:35 p.m., a request was made for Resident # 10's daily weights. On 2/8/11 at 9:30 a.m., the RN/Nurse Consultant provided documentation of weights for Resident # 10. The RN/Nurse Consultant indicated the	F 282	**Other residents having the potential to be affected:** All residents have the potential to be affected. All residents' physician orders and care plans were reviewed for completion and documentation of such orders. **Measures to ensure practice does not reoccur:** Licensed nursing staff were re-educated /in-serviced on 2/28/11 on following physician orders and the documentation of such. See Attachment E. The DON/designee will monitor nurses' notes, medication and treatment sheets daily Monday through Friday x 30 days, then weekly x 4 weeks, and then monthly thereafter. Any non-compliance will be addressed immediately through correction, re-education and disciplinary action, as warranted. **This Corrective Action will be monitored by:** The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. **Plan of Correction date: 3/12/2011**	

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F 282	Continued From page 8 facility found weights documented on their 24 hour sheets. No documented weights were found for 1/22/11, 2/1/11, 2/4/11 and 2/5/11. 3.1-35(g)(2)	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a foot rest to prevent foot drop for 1 of 3 resident reviewed for restorative services in a sample of 12 (# 29). Findings include: The initial tour was conducted on 2/7/11 between 10:00 a.m. and 10:30 a.m., with LPN # 1. During the tour, Resident # 29 was observed in the hallway by the nurses' station. The resident sat in a high back wheelchair with no foot pedals or foot board. The resident's feet hung down, pointing downward with no support. Resident # 29 was observed on 2/7/11 in the same manner, in the wheelchair, with her feet dangling, at 12:00 p.m., 12:10 p.m., and 12:40 p.m. Resident # 29 was observed in bed at 1:45 p.m. The resident's feet did not reach the end of the bed. The resident's feet were pointed downward	F 311	**F311 Treatment/Services to Improve/Maintain ADL's** It is the policy of this facility to provide the appropriate treatment and services to maintain or improve the residents' abilities. **Corrective Action for residents affected:** Resident #29 has a foot board on reclining chair and foot support in bed. Care plan for resident #29 was reviewed and is current with all interventions. **Other residents having the potential to be affected:** All other dependant residents have the potential to be affected. All residents using wheel chairs for mobility were assessed for proper foot support and foot drop prevention. Care plans were reviewed along with C.N.A. assignment sheets for documentation of such prevention items. See Attachment F.	

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F 311	Continued From page 9 towards the foot board with her toes extended down instead of up. Resident # 29 was observed on 2/8/11 in the wheelchair with no foot rest or foot board, which caused her feet to dangle from the end of the chair at 7:00 a.m., 7:25 a.m., 8:30 a.m., and 8:50 a.m. At 8:55 a.m., CNA # 3 and CNA # 4 were observed assisting Resident # 29 to bed. The resident's feet did not reach the end of the bed. The resident's feet were pointed downward towards the foot board with her toes extended down instead of straight up. Resident # 29 remained in bed until lunch time. The resident was again observed in the wheelchair with no foot pedals or foot board causing her feet to dangle and hang downward towards the floor. The clinical record of Resident # 29 was reviewed on 2/8/11 at 8:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, hip repair, arthritis, and heart disease. The Quarterly Minimum Data Set Assessment (MDS), dated 12/27/10, indicated Resident # 29 was dependent on staff for transfer. The MDS indicated Resident # 29 had loss of range of motion in both lower extremities. The clinical record did not provide any therapy department notes. The clinical record did not include any restorative nursing notes. The care plan, dated 12/30/10, did not include a plan of care for positioning or range of motion.	F 311	**Measures to ensure practice does not reoccur:** Nursing staff were re-educated on prevention of foot drop and proper feet placement in wheel chairs on 2/28/11. The DON/designee will monitor for proper feet placement and prevention of foot drop daily x 2 weeks, then weekly x 2 weeks, then monthly thereafter. See attachment G. Any non-compliance will be addressed immediately through correction, re-education and disciplinary action, as warranted. **This Corrective Action will be monitored by:** The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. **Plan of Correction date: 3/12/2011**	

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F 311	Continued From page 10 The Nurse Consultant was interviewed on 2/9/11 at 4:00 p.m., during the daily exit meeting regarding the lack of positioning device to help prevent foot drop for Resident # 29. On 2/10/11 at 8:25 a.m., the Nurse Consultant was again interviewed. The Consultant indicated the resident did not have a foot board or pedals for the wheelchair to prevent her feet from dropping downward. She indicated there was no pillow or device at the end of the resident's bed to prevent the resident's feet from dropping downward.	F 311		
F 371 SS=E	3.1-38(a)(3) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean in order to limit the potential for food contamination. This failure had the potential to affect 40 of 41 residents who ate 3 meals a day from the facility kitchen.	F 371	**F371 Food Procure, Store/Prepare/Serve – Sanitary** The facility must store, prepare, distribute and serve food under sanitary conditions. **Corrective Action for residents affected:** No residents were affected. The large four shelf stainless steel shelving unit was cleaned. The stainless steel milk cooler/refrigerator was cleaned. The stainless steel four shelf unit between the stove and freezer was cleaned. The stainless steel shelf above the steam table serving line was cleaned. The black plastic knife holder has been cleaned. Maintenance cleaned vent and the front serving window/roll down closer. Cabinets have been cleaned and repainted. Stove, grill, broiler, and shelf of stove have all been cleaned. The 5 ft. freezer has been cleaned.	

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F 371	Continued From page 11 Findings include: The dietary sanitation tour was conducted on 2/8/11 between 9:00 a.m. and 10:00 a.m., with the Dietician and Dietary Manager (DM). The following observations were made: The kitchen was entered through the dish room. Across from the dishwasher in the dishroom was a large four shelf stainless steel shelving unit that held clean glasses, coffee cups, and trays. Each of the four shelves was covered in a black, sticky, substance that could not be removed with the hand. The glasses and coffee cups sat directly on these soiled shelves. To the right of the dishroom/kitchen door was a large stainless steel milk cooler/refrigerator. There was an over hang all along the top of the cooler. The over hang caused a gap in the stainless steel all around the top of the refrigerator. Long, gray dust hung down from the over hang. Long stands of gray and black dust hung from the refrigerator/milk cooler vents. The dirt moved about as the glasses and cartons of milk were moved from the cooler to the serving line and back again. A stainless steel four shelf unit sat in between the stove and a freezer. The shelving unit held pots and pans. All four shelves were covered with a black and gray sticky substance that could not be removed with touch. The pots and pans sat upside down and directly on the soiled shelves. A stainless steel shelf was above the steam table serving line. The shelf was covered in a gray, and black dust and sticky substance. The shelf held the menus and resident food tickets. The food	F 371	**Other residents having the potential to be affected:** All residents have the potential for being affected. See below for corrective measures. **Measures to ensure practice does not reoccur:** Dietary staff were re-educated on cleaning schedules, overall equipment sanitation and importance of scheduled cleaning. In-service was conducted by Administrator and Dietary Manager on 2-11-11, see attachment H. The Dietary Manager or designee will complete sanitation rounds daily (Monday through Friday) for 4 weeks; then twice weekly for 4 weeks; then weekly to ensure continued compliance indefinitely. See attachment I for monitoring tool. Any non-compliance will be addressed immediately through correction, re-education and disciplinary action, as warranted. **This Corrective Action will be monitored by:** The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. **Plan of Correction date: 3/12/2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155531	A. BUILDING _____ B. WING _____	C 02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBROOK VILLAGE	850 ASH ST HUNTINGTON, IN 46750

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F 371	Continued From page 12 tickets were put on the resident's tray after the food was prepared from the steam table pans directly below the soiled shelf. A black plastic knife holder was attached to the wall next to the stove. The knife holder had nine slots, but only five knives. The top of the holder was covered with a black, brown, gray, sticky substance. Two of the five knives in the holder were dirty. At 10:00 a.m., on 2/8/11 the DM was interviewed. She indicated she had been working on cleaning schedules but they were not completed or posted. She further indicated the prior DM had taken down the kitchen cleaning schedules to work on them. At 10:15 a.m. on 2/8/11, the DM provided cleaning schedules for review, dated September 2010. She indicated they were the last cleaning schedules completed in the kitchen. Information was requested at the daily exit meeting on 2/8/11 at 4:00 p.m., regarding the cleaning of the kitchen. No further information was provided regarding cleaning in the kitchen since September 2010.	F 371		
F 465 SS=D	3.1-21(i)(2) 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	**F465 Safe/Functional/Sanitary/ Comfortable Environment** The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155531	A. BUILDING _____ B. WING _____	C 02/10/2011

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F 465	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the kitchen in a clean and sanitary manner, free from dirt and debris. This failure had the potential to affect 40 of 41 residents who ate 3 meals a day from the facility kitchen. Findings include: The dietary sanitation tour was conducted on 2/8/11 between 9:00 a.m. and 10:00 a.m. with the Dietician and Dietary Manager (DM). The following observations were made: A serving window was in the front of the kitchen used to serve the resident food trays from the serving line to the dining room. The kitchen side of the window was covered with rust and a sticky substance that could not be removed with a finger. White cupboards holding spices, cups, and cooling racks were located to the right of the serving window. The paint around the cupboard handles was cracking. The cracks were caked with a brown stain. The oven and stove sat next to the knife holder. The oven and stove had streaks of black down the front from top to bottom. The oven door handle was sticky. The stove's grill well was full of a black stain. A stainless steel plate behind the stove burners was covered with streaks of black and brown substance. The broiler pan was covered in crumbs and black sticky substance. Two oven mitts sat on a shelf on top of the stove. The shelf was coated with a black sticky	F 465	**Corrective Action for residents affected:** No residents were affected. The large four shelf stainless steel shelving unit was cleaned. The stainless steel milk cooler/refrigerator was cleaned. The stainless steel four shelf unit between the stove and freezer was cleaned. The stainless steel shelf above the steam table serving line was cleaned. The black plastic knife holder has been cleaned. Maintenance cleaned vent and the front serving window/roll down closer. Cabinets have been cleaned and repainted. Stove, grill, broiler, and shelf of stove have all been cleaned. The 5 ft. freezer has been cleaned. **Other residents having the potential to be affected:** All residents have the potential for being affected. See below for corrective measures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155531	A. BUILDING _____ B. WING _____	C 02/10/2011

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F 465	Continued From page 14 substance that could not be removed with a finger. The top of the five foot tall freezer next to the pots and pans shelf was coated with dried food particles and rust. At 10:00 a.m., on 2/8/11 the DM was interviewed. She indicated she had been working on cleaning schedules but they were not completed or posted. She further indicated the prior DM had taken down the kitchen cleaning schedules to work on them. At 10:15 a.m. on 2/8/11, the DM provided cleaning schedules for review, dated September 2010. She indicated they were the last cleaning schedules completed in the kitchen. 3.1-19(f)	F 465	**Measures to ensure practice does not reoccur:** Dietary staff were re-educated on cleaning schedules, overall equipment sanitation and importance of scheduled cleaning. In-service was conducted by Administrator and Dietary Manager on 2-11-11, see attachment H. The Dietary Manager or designee will complete sanitation rounds daily (Monday through Friday) for 4 weeks; then twice weekly for 4 weeks; then weekly to ensure continued compliance indefinitely. See attachment I for monitoring tool. Any non-compliance will be addressed immediately through correction, re-education and disciplinary action, as warranted. **This Corrective Action will be monitored by:** The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. **Plan of Correction date: 3/12/2011**	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 155531	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBROOK VILLAGE	850 ASH ST HUNTINGTON, IN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure care plan interventions were specific related to activities of interest for 1 of 12 residents reviewed for care plans in a sample of 12 (Resident # 17).

Findings include:

1. Review of the clinical record of Resident # 17 on 2/8/11 at 2:00 p.m., indicated the following: Resident # 17's diagnoses included, but were not limited to, seizure disorder, hypertension and mental retardation.

Resident # 17's most recent OBRA (Omnibus Reconciliation Act) assessment, dated 4/22/09, indicated Resident # 17 "...would benefit from participating in some type of specialized services through an agency that would offer him a variety of leisure activities to participate in the community for social and cognitive stimulization [sic]...."

An "Individual Habilitation Information Plan," dated 11/1/10, indicated "...specialized rehabilitation and treatment needs: 1. Monitoring medical needs...2. Residential svc (service) for 24 (twenty-four) hr. (hour) supervision in supportive environment...5. Therapy as needed for rehabilitation...Habilitative training for self-help care...personal goals: 1. Accept neurological eval (evaluation)...Will participate in rehab. therapy as needed...Accept N.F. (nursing facility) living environment...Participate in habilitative training...Participate in mental health svc...." Further documentation indicated "...Other: Per voiced preference: (Resident # 17's name) chooses not to participate in specialized/outside agency svcs (services)."

The most recent QMRP (Qualified Mental Retardation Professional) notes, dated 1/28/11, indicated "OBRA Services: resident preference to not participate in Day Programming...."

Interview with the RN/Nurse Consultant and Administrator on 2/10/11 at 8:55 a.m., indicated Resident # 17 likes to go to the Dollar Store with the Maintenance Director and participates in facility activities/outings.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 155531	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/10/2011

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	Continued From Page 1

Resident # 17's care plan for activities indicated "...outings..." with no indication as to what type of outing and how often the facility would take Resident # 17 on an outing.

3.1-35(a)

F279 Comprehensive Care plans
The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Corrective Action for residents affected:
Resident #17's care plan was revised on 2/10/11 to address resident's preferences related to outings.

Other residents having the potential to be affected:
No other residents were affected, although all residents would have the potential to be affected. Activity Care plans for all residents were reviewed and updated as needed to address residents' activity preferences.

Measures to ensure practice does not reoccur:
Activity care plans for each resident are updated and reviewed quarterly. The Activity Director has been in-serviced on 2/24/11 regarding the need to address residents' specific activity preferences on residents' care plans per the corporate Activity Consultant. Administrator or designee will monitor during quarterly care plan meeting that activities of interest are addressed on each individual care plan. Administrator will sign the interdisciplinary care plan conference record to ensure monitoring. See attachment A.

This Corrective Action will be monitored by:
Administrator or designee will monitor during quarterly care plan meeting that activities of interest are addressed on each individual care plan. Administrator will sign the care plan audit tool to ensure monitoring. Monitoring will be ongoing to ensure continued compliance.

Plan of Correction date: 3/12/2011